## **Clear Image Eye Center**

## **Notice of Privacy Practices:**

I hereby acknowledge the receipt of Center.	Notice of Privacy Practi	ces from Clear Image Eye	
Signature of the Patient/Guardian	Relationship	Date	
Authorization for Use and Disc	losure of Protected Ho	ealth Information:	
Persons to Whom Information May We can not disclose any information		e patient unless listed below	
Name		Relationship to Patient	
Name	Relationship to Patient		
Name	Relationship to Patient		
Right to Terminate or Revoke Authorization will remain valid patient's personal representative. You submitting a written revocation to Community, Privacy/Compliance Office	unless revoked or termina ou may revoke or termina Clear Image Eye Center. Y	ate this authorization by You should contact Kristi	
Potential for Re-Disclosure Information that is disclosed under to person or organization to which it is protected under the federal privacy	sent. The privacy of this		
Signature of the Patient/Guardian	Relationship	Date	